JD(NY)-10-21
Newark, NJ

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
DIVISION OF JUDGES

COUNTY CONCRETE CORPORATION

Respondent

and **Case No.: 22–CA–238625**

LOCAL 863, INTERNATIONAL BROTHERHOOD OF TEAMSTERS

Charging Party

Michael P. Silverstein, Esq.,
for the General Counsel.
Brian P. Shire, Esq.,
for Respondent.
Kenneth I. Nowak, Esq.,
*f*or the Charging Party

DECISION

STATEMENT OF THE CASE

JEFFREY P. GARDNER, Administrative Law Judge. Pursuant to the Board's decision in *William Beaumont Hospital*, 370 *NLRB* No. 9 (2020), on November 5, 2020, I conducted a trial via Zoom Government in this case, during which all parties were afforded the opportunity to present their evidence.[1] The complaint (GC Exh. 1(c)),[2] alleges that Respondent violated Section 8(a)(5) and (1) of the Act by unilaterally changing the insurance carrier or third-party administrator for its self-funded medical plan.

Respondent denied the essential allegations in the complaint, and asserts that it was privileged to make the changes it made. (GC Exh. 1(e)). After the trial, the General Counsel, Charging Party, and Respondent all filed timely briefs, which I have read and considered. Based on those briefs and the entire record, including the testimony of the witnesses and my observation of their demeanor, I make the following

[1] Cristina Von Spiegelfeld, a Board attorney, served as Courtroom Deputy to assist with the Zoom technology during the trial, and is recused from otherwise participating in the case.

[2] Abbreviations used in this decision are as follows: "Tr." for the Transcript, "Br." for party briefs, "GC Exh." for the General Counsel's Exhibits, "CP Exh." for the Charging Party's Exhibits, "R. Exh." for Respondent's Exhibits, and "Jt. Exh." for Joint Exhibits. Specific citations to the transcript and exhibits are included only where appropriate to aid review, and are not necessarily exclusive or exhaustive.

FINDINGS OF FACT

I. JURISDICTION

Respondent is a New Jersey corporation that manufactures and supplies sand, gravel and ready-mix concrete at various Northern New Jersey facilities, including East Orange, Flemington, Kenvil, Morristown, Landi, and Oxford, New Jersey. During the preceding 12-month period, it purchased and received at these facilities goods and supplies valued in excess of $50,000 directly from suppliers located outside the State of New Jersey. Accordingly, I find, as Respondent admits, that it is an employer engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act. It is also admitted, and I hereby find, that the Union is a labor organization within the meaning of Section 2(5) of the Act.

II. ALLEGED UNFAIR LABOR PRACTICES

THE FACTS

Background

Respondent is a materials supplier to the construction industry in central and northern New Jersey. Respondent delivers its products to construction sites and residential homes. Its employees work in different facilities throughout New Jersey as drivers, mechanics, laborers and heavy equipment operators. Local 863, International Brotherhood of Teamsters (the Union) represents approximately 125 of Respondent's employees, and has since 2009.

Respondent's majority owner and President since 1978 has been John Crimi, who testified at the hearing for Respondent. Testifying at the hearing for the General Counsel were the Union's Secretary-Treasurer Alphonse Rispoli and Union Chief Steward Raymond Bonelli, who is also a unit employee. Health Benefit Consultant Kevin Klemm also testified as an expert witness for the Charging Party.

There are multiple collective-bargaining agreements between the parties that cover the facilities in East Orange, Flemington, Kenvil, Morristown, Landi, and Oxford, New Jersey, and none had expired when Respondent took the disputed action on January 1, 2019. The collective-bargaining agreements between Local 863 and the Kenvil and Morristown ready-mix plants did expire shortly thereafter on January 15, 2019. The issues involved here are the same for all the collective-bargaining agreements, which share the following common language under "Article 39. Insurance Benefits":

> "The Employer agrees to continue to provide health insurance for full-time bargaining unit employees at the same level of benefits as it provides to its non-union full-time and management employees.
>
> …
>
> The Employer reserves the right to change insurance carriers at its discretion, and to make changes that may be required under the Affordable Care Act,[3] provided

[3] Respondent does not claim that any changes made were required under the Affordable Care Act.

that (i) any such changes shall apply the same to all union and non-union employees[4] and (ii) the level of benefits shall remain substantially the same."

(Jt. Exhs. 1–5.)

The primary issue in this case is whether Respondent had a sound arguable basis to believe that the changes made to the employees' health care plan maintained substantially the same level of benefits that were provided previously.

Healthcare Coverage Prior to 2019

Since before the Union began representing the bargaining units in 2009, Respondent has self-funded its health plan, which means it was responsible for paying all of the claims incurred under the plan. Like most self-funded plans, Respondent contracted with a third-party administrator (TPA) to handle the processing and determination of health plan claims, and throughout the periods that the Union's collective-bargaining agreements were in effect, Respondent's TPA was Horizon Blue Cross Blue Shield.

As a result of this arrangement, Respondent's employees had access to in-network health benefits through Horizon Blue Cross Blue Shield. That meant there was a network of roughly 44,000 in-network doctors in New Jersey alone that employees could use, as well as being entitled to in-network benefits at 6000 hospitals nationwide, with access to over 600,000 in-network providers nationwide.

As a TPA, Horizon did not have any discretionary authority to determine what medical services Respondent's medical plan covered. Respondent, as a self-funder, had the authority to determine what medical services were covered under the medical plan. Similarly, Respondent determined the annual deductibles, copays, coinsurance, and wellness eligibility requirements. Horizon did not assume any financial risk for the liability of medical claims incurred by a plan participant under the plan.

Instead, under the administrative services agreement between Respondent and Horizon (Jt. Exh. 15), Horizon would make initial determinations of eligibility for claims, and Horizon would make payments to hospitals and physicians in accordance with negotiated prices, and be reimbursed by Respondent. Horizon offered Respondent discounts when its employees sought medical services from in-network providers.

In 2018, Horizon Blue Cross and Blue Shield administered two plans for Respondent's employees, a high plan and a base plan. The difference between the two plans were the cost of deductibles. In 2018, Bonelli had the high plan. The cost for his then deductible was $500. In order to obtain the deductible, employees including Bonelli had to fulfill the requirements of a wellness physical.

Prior to the collective-bargaining agreement negotiations in 2015, there was no high and base medical plan. Respondent implemented a high plan and base plan for the 2016 plan year as part of the initial CBAs with the Union. If employees obtained a complete physical and completed the necessary paperwork in 2015, they would receive a discount on their 2016 in-network deductible placing them on the high plan. The wellness program was important for Respondent for its preventative purposes, which helped manage costs.

[4] It is not alleged that any changes made applied differently to union versus nonunion employees.

It is undisputed that Respondent previously made various changes relating to the high medical plan effective January 1, 2017. None of these changes were negotiated with the Union prior to being implemented. The Union did not grieve any changes made to the County medical plan in 2017. In 2018, County made additional changes to the medical plan that impacted the high plan and the base plan. Again, the Union did not grieve the changes to the 2018 base plan changes either.

Respondent Notifies Employees of Impending Changes to their 2019 Medical Plan

In December 2018, upon the request of Respondent's attorney Hope Goldstein, Alphonse Rispoli met with Goldstein and Crimi. At that meeting, Crimi expressed that he wanted to extend the contract set to expire on January 15, 2019, for an additional year and give employees a 25-cent raise. Goldstein also expressed to Crimi that Respondent had high costs associated with Horizon Blue Cross Blue Shield and therefore wanted to make changes to the plan. He did not specify what those changes might be, and did not identify any new providers by name at that time. Rispoli refused to discuss any changes until the upcoming contract negotiations, and Crimi agreed.

Nevertheless, without negotiating for changes, in late December 2018, Respondent distributed to employees with their paychecks a one-page memo titled "County Concrete New Medical/Rx Plan Highlights" that indicated their health insurance would be changing effective January 1, 2019. (Jt Exh. 29.) The memo identified "Cypress" as the new medical provider and "Magellan" as the new prescription drug plan provider, and provided contact telephone numbers and Group IDs for each.

This was the first mention of either of these two entities by name. The memo did not include a summary plan description (SPD) or a summary of benefits and coverage (SBC),[5] nor did it provide information regarding what the new benefit levels, copays or deductibles would be. It instructed employees to call Cypress and/or Magellan with any questions they may have about their coverage, and to call their doctors in advance to have them in turn call Cypress to confirm coverage.

Employees were surprised to see this change and asked Chief Steward Raymond Bonelli if he knew anything about the changes. However, this was the first time Bonelli was informed that the employee's health insurance would be changing the following year. Bonelli called Rispoli to ask about the document, and Rispoli told him that he also did not know about the impending change to the medical plan.

Union Response to Changes in Medical Plan

After hearing from Bonelli, around December 28, 2018, Rispoli called Crimi to inquire about the memo. Crimi responded, "I had to change the plan. We're losing money. I had to change the plan." Rispoli reiterated that they should discuss the changes during negotiations and asked about the document and the changes it described. Crimi said he would send Rispoli information regarding the changes, which Respondent maintains were recommended to it by its insurance representative, "USI."

[5] The terms SPD and SBC are used interchangeably here.

Bonelli consulted with Rispoli about creating a petition to ask the company to explain the new health insurance plan, which they did. The first page was a letter to Crimi and Vice President of human resources, Steve Parisi, asking for the information on the new medical plan. (GC Exh. 4.) The second page was a lined paper where employees could sign their names to show interest in receiving additional information on the insurance, which about 40 or fewer employees signed. The petition was handed to Crimi and Parisi in mid-to-late January of 2019.

Around January 15, 2019, Rispoli met with union members to get their proposals for the upcoming CBA negotiations. Overwhelmingly, the biggest issue was the sudden change to the health plan. Members still did not have additional information regarding the changes described in the County Concrete New Medical/Rx Plan Highlights, specifically regarding Cypress and Magellan. They wanted to return to Horizon Blue Cross Blue Shield.

The Union received numerous calls from stewards, members, and their spouses with questions and concerns regarding the new medical plan. But, Rispoli had not received a response or information from Crimi regarding the information he requested from Crimi during their late December phone call. On January 23, 2019, Rispoli wrote a letter (Jt. Exh. 9) to Crimi requesting information, including the "formal and official name of the insurance carrier/company (the term insurance carrier will cover both) or if not an insurance company, then of the TPA who now provides or manages health insurance. Please specify whether it is an insurance carrier or TPA." The letter also requested the SPDs for both the prior and new health plan, the provider network available to employees and additional information about the plan. (Jt. Exh. 9.)

Crimi responded in a letter dated January 28, 2019, informing Rispoli that Respondent had been self-insured and claiming to be the insurance carrier of all hourly and management employees for the previous 18 years. (Jt. Exh. 10.) Crimi's letter further explained that Respondent had changed the administration from Horizon Blue Cross Blue Shield to Cypress Benefit Administrators. It promised that an SPD would be forthcoming, but did not otherwise provide information about the provider network or other information about Cypress.

On February 4, 2019, Rispoli sent a response letter to Crimi regarding the change in insurance and reiterated the request for information about, including another request for an SPD, which still had not been provided. Rispoli also disputed the characterization by Crimi that Respondent was the insurance carrier for the employees, arguing that being self-insured and being an insurance carrier are two separate things. (Jt. Exh. 12.)

First CBA Negotiation Meeting

The first CBA negotiation meeting was held on February 7, 2019. Crimi and Goldstein were present on behalf of the Respondent, while Rispoli was lead negotiator for the Union. The main topic was healthcare. Among other proposals, the Union presented the Local 863 Health Plan. Shop stewards and the committee of workers asked about the Cypress plan and expressed concern about not having online access to any information regarding Cypress. Crimi stated that Respondent was "working on it" and "working through it." Crimi told them not to worry and that he would "take care of it." At this meeting, Rispoli was handed two packets titled "Summary of Benefits and Coverage" (SBC) which represented Cypress's High and Basic plans for Respondent. (Jt. Exhs. 21 and 22.)

On February 13, 2019, Rispoli received a seven-page letter with Respondent's responses to questions regarding the health insurance posed by Rispoli at the February 7 negotiation meeting. (Jt. Exh. 14.) Rispoli compared Respondent's answers to the packet given to him during that meeting, and found inconsistent language in the two sets of documents. Significantly, the SBCs referred to network coverage, but the February 13, 2019 document said there was no network coverage in the new plan. After receiving the February 13 letter, Rispoli called Crimi and asked about the discrepancies. Crimi responded that an incorrect SBC had been sent and that a corrected version would be provided.

February 24, 2019 Informational Meeting Hosted by Respondent

In or about mid-February 2019, Respondent's front office gave Bonelli a flyer to hang up on the bulletin boards of the plants. (Jt. Exh. 32.) The flyer contained information regarding a meeting to be hosted by Respondent on February 24, 2019. The flyer also announced that Respondent would be introducing a new service called Compass Professional Health services.

On February 24, 2019, the meeting took place, with over 40 employees in attendance. The stated purpose of the meeting was for employees to learn about the new insurance benefits. Respondent's insurance representative USI's Dennis Bartley gave a slideshow presentation and took questions from employees. (Jt. Exh. 8.) When asked about whether employees had access to a network where they could check if certain physicians participated in their insurance, Bartley explained that "all" doctors belonged to the network. He went on to explain that doctors only had to call Cypress and Cypress would onboard them. Bartley also said that a Cypress Insurance representative would speak to doctors and if the doctors were still worried about not being paid, Cypress could pay in advance using a credit card.

Employees were given a multi-page document which made reference to "in-network provider[s]," but the employees were never given a network list. Bartley did not say whether there was an actual directory of doctors that employees could reference to confirm whether they were in the employees' network.

Also at this meeting, Compass Professional Health services was introduced to employees as a concierge service that would answer questions and try to find doctors or specialists on their behalf. The Program Services Agreement between Respondent and Compass Professional Health services entered into effect on March 1, 2019.

The Union Continues to Request a Corrected SBC and Files an Unfair Labor Practice

On March 15, 2019, Rispoli sent a letter via fax and first-class mail asking for the promised corrected/updated version of the Cypress SBC. Rispoli then sent a letter to all members on March 18, 2019 to notify them that the Union had filed an unfair labor practice, and that the Union was still trying to get information regarding the medical plan.

On March 25, 2019, Respondent sent what purported to be the updated SBC. However, the same network language from the previous SBC was still present on the updated March 25, 2019 SBC. Rispoli called Crimi to inquire about this, and Crimi told him the wrong SBC had been sent.

Thereafter, on May 29, 2019, Crimi sent a two-page letter to all of Respondent's employees, which detailed changes to Respondent's medical plans, by then in effect for 5 months. The letter blamed the high cost of maintaining the 2018 Horizon medical plans as having forced Respondent to "explore alternatives" to reduce the projected increase in its healthcare costs. It also announced the implementation of additional changes that were to be effective August 1, 2019. (Jt. Exh. 9.)

In August 2019, Respondent created and mailed employees an amended guide detailing the changes made to the plan and the current status of the plan. In late August 2019, Crimi sent a letter to Respondent employees announcing that employees would have a network of doctors available to them, the PCHS doctor network. Subsequently, during the last quarter of 2019, for the first time under the new Cypress plan, Crimi agreed to pay a fee for employees to have access to this doctors' network.

Bonelli Attempts to Use Cypress Insurance to See His Primary Care Doctor

In January of 2019, Bonelli attempted to see his regular primary care doctor who is affiliated with Crystal Run Healthcare in Middletown, New York. Bonelli called ahead to verify that his new Cypress insurance would be accepted. A receptionist said Cypress was not in the system and that she had never heard of it. The receptionist referred Bonelli to the billing department. The person working in the billing department said she did not think the office accepted Cypress. Bonelli asked the billing department representative whether his insurance company could contact her, and she said yes.

Bonelli called Cypress Insurance Company and explained that his doctor's office had never heard of Cypress and needed additional information. Crystal Run eventually accepted Cypress Insurance and Bonelli was able to see his primary care physician. It took over 10 phone calls to Crystal Run and Cypress for his doctor's office to accept his Cypress insurance. Crystal Run explained that the approval of a new insurance company had to go before their Board of Directors.

Before Bonelli could see his physician, he was asked to sign a new form that said he would be responsible for any additional fees that were charged beyond what Cypress was authorized to pay, which is otherwise known as balance billing. Bonelli had not been asked to sign a similar form when he had Horizon Blue Cross Blue Shield Insurance because there is no balance billing with in-network providers.

Bonelli Attempts to Use Cypress Insurance and Compass Professional Health Services to See a Specialist

Bonelli had to see a specialist for an appointment in April of 2019 for a diagnostic colonoscopy. He had gotten an identical procedure 5 years prior for which he paid a $50 copay because he had met his deductible. He had been an employee of Respondent at that time. The specialist he sought to use was Dr. Gershenhorn who was also affiliated with Crystal Run Healthcare.

Bonelli called the doctor's office and gave his insurance information to the receptionist. The receptionist said his Cypress insurance was not in the system. Bonelli spoke to Rosa Lopez, the Compass concierge health pro on the phone and asked for her help to get Dr. Gershenhorn's office to accept Cypress Insurance for this procedure. At this point Bonelli began communicating with Lopez through email.

On March 12, 2019, Lopez emailed Bonelli. Bonelli was confused because the process he initiated with Crystal Run with his primary care doctor appeared to not apply anymore. He called Crystal Run and was transferred to billing office. This billing office representative said she would let Dr. Gershenhorn's office know that their system might not be updated. Lopez' March 12, 2019 email also mentioned a Dr. Patel who was apparently willing to work with Bonelli's policy and may be able to help. (GC Exh. 5.) No additional information was provided about this doctor.

By March 12, 2019, Bonelli had scheduled his colonoscopy but did not know what his out-of-pocket costs for his procedure scheduled the following month would be. Between March 12 and 19, 2019, Bonelli confirmed with Crystal Run that they would accept Cypress Insurance. Bonelli then asked Lopez for information regarding what he would be responsible for paying. It took Bonelli more than six phone calls to Lopez, Dr. Gershenhorn's office, and Peggy in human resources to get the issues resolved for the colonoscopy.

On March 19, 2019 at 3 p.m., Lopez emailed Bonelli with a breakdown of the out-of-pocket costs for the doctor. In that same email, Lopez asked Bonelli to have Dr. Gershenhorn's office use an in-network anesthesiologist. Bonelli claimed his deductible was not supposed to be that high nor did he have any control over what anesthesiologist was going to be used at his procedure. When Bonelli was under Horizon, he was never told it was his obligation to find an anesthesiologist.

Bonelli asked Lopez questions regarding the anesthesiologist, the incorrect deductible listed in Lopez' email to him, and the co-insurance charge which he had never been charged before. Bonelli was supposed to be on the high plan which meant his deductible should have been $1000.

In addition, under the Horizon Blue Cross plan in 2018, there was no coinsurance associated with the high plan because employees only had the high plan if they completed the wellness program. On April 8, 2019, Lopez informed Bonelli that if there was still a wellness program, she did not know anything about it.

Bonelli never got his colonoscopy because the cost was too high, and he was unable to ascertain for sure what exactly it would end up costing him. There was a medical provider who was willing to accept the Cypress Medical Plan for Bonelli's colonoscopy. Since terminating the colonoscopy procedure, Bonelli has not had any other medical services performed other than routine visits, for which he has been able to use Cypress.

Bonelli Attempts to Use Magellan for His Prescription

Bonelli was prescribed and took Invokana to treat Type 2 diabetes in 2018 under the Horizon Blue Cross prescription drug plan. His associated out-of-pocket cost was either $50 or $60 copay for a 90-day supply. When the prescription plan switched to Magellan in 2019, Bonelli's out-of-pocket cost for the same prescription was $279 or $269 for the same 90-day supply.

Other Changes to the Employees' Health Plan

In addition to the loss of the Horizon Blue Cross network caused by Respondent's switching to Cypress and Magellan, there were other changes that went into effect as of

January 1, 2019. One major change was that spouses who had the ability to be covered under their own separate plan were not eligible to be covered under Cypress. This "spousal carve-out" did not exist under Horizon, and though Respondent maintains that this limitation was subsequently taken out of the plan, it is undisputed that it was a part of the initial SPD provided to the Union in February 2019.[6]

Another change related to the coverage for services including anesthesia, dialysis, diagnostic x-rays, durable medical equipment, home health care, hospice care, newborn care and wigs, all of which were 100 percent covered under the previous plan. Under the new Cypress plan, these services were covered only up to 80 percent of a calculated "maximum allowable charge," leaving the employee responsible for both the remaining 20 percent, as well as 100 percent of any amount exceeding that "maximum allowable charge." These additional amounts are known as a "balance bill," which did not exist under the Horizon network coverage.

Respondent maintained at the hearing that if employees received a balance bill, Respondent would pay the full amount of the balance bill without question. However, that guarantee was never put into writing, nor did Crimi ever make that explicit representation to employees. Aside from one case of a balance bill for a nonunion employee, Respondent maintains that every other claim was paid by the company and that from January 1, 2019, to at least November 5, 2020, Respondent did not allow any employee to be personally liable for a balance bill.

Finally, based on the SPD that was eventually provided to employees, the new Cypress plan eliminated coverage altogether for acupuncture, and at least initially also excluded coverage for audiology. It increased the copay for emergency room visits from $100 to $500. It doubled the deductible for employees who had participated in Respondent's wellness plan from $500 single and $1000 family to $1000 single and $2000 family.

Credibility

My factual findings set forth above are based primarily on uncontradicted testimony and authentic documentary evidence. To the extent there are conflicts, I find that witnesses Alphonse Rispoli and Raymond Bonelli were both very credible. They responded directly to questions from counsel on direct and cross-examination, and their testimony was consistent and appeared forthright.

The Union's witness, Kevin Klemm, whose testimony was essentially uncontradicted, was likewise credible. He had detailed knowledge of the subject matter, and provided helpful context for the hearing and my decision.

I found John Crimi much less credible. His testimony seemed directed at supporting Respondent's position that little had changed from 2018 to 2019, despite a wealth of evidence to the contrary. When confronted with those specific changes, his knowledge and recollection suddenly became vague.

[6] Likewise, during the last quarter of 2019, Crimi agreed to pay a fee for employees to have a limited doctors' network associated with Cypress, but it is not disputed that at the start of the year, no existing doctors' network was included or made available to the employees or the Union.

ANALYSIS

Respondent unlawfully modified the parties' contract with regard to the employees' health care plan without first notifying and bargaining with the Union.

This case involves Respondent's unilateral change to the third-party administrator for its health care plan, without giving the Union notice or an opportunity to bargain over the change. I find that Respondent's actions constitute an unlawful unilateral change in violation of Section 8(d) and Section 8(a)(5) and (1) of the Act.

In cases where a collective-bargaining agreement is in effect, an employer's modification of a contractual provision which relates to a mandatory subject of bargaining without the union's consent violates Section 8(a)(5) of the Act. *Allied Chemical & Alkali Workers of America v. Pittsburgh Plate Glass*, 404 U.S. 157, 185 (1971); *St. Vincent Hospital*, 320 NLRB 42 (1995).

Section 8(d) of the Act prohibits an employer that is party to a collective-bargaining agreement with a union from terminating or modifying that contract without the union's consent. An employer who makes such an unlawful mid-term modification in violation of Section 8(d) has failed to bargain collectively and in good faith with the exclusive bargaining representative of its employees in violation of Section 8(a)(5) and (1) of the Act

Indeed, the Board recently reiterated in *The Voorhees Care and Rehabilitation Center*, 371 NLRB No. 22 (2021), Section 8(a)(5) of the Act provides that it is an unfair labor practice for an employer to "refuse to bargain collectively with the representatives of [its] employees." In general, an employer violates Section 8(a)(5) if it makes a unilateral change to an existing term or condition of employment without bargaining to impasse with its employees' collective-bargaining representative over the proposed change. *NLRB v. Katz*, 369 U.S. 736, 743 (1962).

In determining whether an employer has modified the parties' contract, the Board adheres to the "sound arguable basis" standard. *Bath Iron Works Corp.*, 345 NLRB 499 (2005). The General Counsel must show that the employer, which claims that it did not unlawfully modify the contract, did not have a sound arguable basis for its interpretation of the contract. Thus, here, the issue is whether Respondent had a sound arguable basis to believe that the changes made to the employees' health care plan maintained substantially the same level of benefits that were provided previously. If so, the parties' CBA would have permitted Respondent to make the changes it made. If not, the changes Respondent made would violate the Act.

Here, the difference in benefits available to employees prior to Respondent's unilateral change to the third party administrator and after that change were both significant and considerable in number. The most significant was the loss of an available network of providers and facilities, arguably one of the most important benefits offered by health insurers and sought after by employees, as evidenced by the reaction of the employees here to the loss of their network.

Where previously employees could readily access the services of over 44,000 in-network providers in the New Jersey region alone, along with access to every acute care

hospital in the state, after Respondent's unilateral change, there was no such network or guarantee. In addition, employees previously had access to coverage for providers and facilities nationwide through the BlueCard program which Horizon participated in and provided. In the absence of any identified network, employees were at the whim of each individual provider from whom they might seek care.

Moreover, the new plan implemented by Respondent involved a serious of considerable increases in the co-pays, deductibles and potential out-of-pocket costs to employees. It also limited spousal participation in the employees' coverage for certain spouses who may have had coverage available elsewhere, a carve-out that did not previously exist.

In addition, beyond the loss of in-network benefits, increased expenses and this spousal carve-out, Respondent's unilateral change even reduced or eliminated coverage for whole categories of care that was previously covered, including acupuncture and audiology. And for those services that continued to be covered, there were no longer contractual caps on what providers could charge, resulting in the risk of balance billing that did not previously exist under Horizon.

Taking these together, I find that Respondent could not and did not have a sound arguable basis to believe that the new health plan as administered by Cypress maintained substantially the same level of benefits that were provided previously under the plan as administered by Horizon Blue Cross. To the contrary, I find that the new plan was substantially inferior to the previous plan, and Respondent's unilateral modification of the plan violated the Act.

In sum, as a result of Respondent's unilateral change to the third-party administrator, the level of benefits provided by Respondent's new health care plan was not substantially the same as the level of benefits previously provided. This was in direct violation of the parties' collective bargaining agreement.

Accordingly, I find that Respondent did make a unilateral change when it changed the employees' insurance carrier or third-party administrator for its self-funded health care plan, and that none of Respondent's explanations for its actions justify that unilateral change.

Conclusions of Law

1. Respondent, County Concrete Corporation, is an employer engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act.

2. The Union, Local 863, International Brotherhood of Teamsters, is a labor organization within the meaning of Section 2(5) of the Act and represents a bargaining unit comprised of workers employed by the Respondent.

3. Since on or about January 1, 2019, by unilaterally changing the third-party administrator for its health care plan which did not provide substantially the same level of benefits previously provided, thereby making mid-term modifications, without the Union's consent, to the health care coverage terms of the parties' collective-bargaining agreements, Respondent has been failing and refusing to bargain collectively and in good faith with the exclusive collective-bargaining representative of

its employees within the meaning of Section 8(d) of the Act in violation of Section 8(a)(5) and (1) of the Act.

4. By unilaterally changing the terms and conditions of employment of its unit employees, the Respondent has been failing and refusing to bargain collectively and in good faith with the exclusive bargaining representative of its employees in violation of Section 8(a)(5) and (1) of the Act.

5. The Respondent's above-described unfair labor practices affect commerce within the meaning of Section 2(6) and (7) of the Act.

Remedy

Having found that Respondent has engaged in certain unfair labor practices, I shall order it to cease and desist therefrom and to take appropriate affirmative action designed to effectuate the policies of the Act.

In particular, I shall recommend that, to the extent it has not already done so, Respondent shall cease and desist from altering the employees' health care plan, including changing its third-party administrator, and make whole its employees for any losses they suffered or out-of-pocket expenses they incurred as a result of Respondent's unlawful conduct. Such amounts shall be computed in accordance with *Ogle Protection Services*, 183 NLRB 662, 683 (1970), enfd. 444 F. 2d 502 (6th Cir. 1971), with interest as prescribed in *New Horizons*, 283 NLRB 1173 (1987), compounded daily as prescribed in *Kentucky River Medical Center*, 356 NLRB 6 (2010).

Further, upon request of the Union, Respondent shall rescind the unilaterally implemented changes in the unit employees' health care plan and restore the coverage, copays, premiums and network available to employees prior to January 1, 2019.

I shall also recommend that Respondent be required to notify employees that it will not alter the insurance carrier or third-party administrator for its health care plan, and that its prior change has been rescinded. Therefore, Respondent will be ordered to post and communicate by electronic post to employees the attached Appendix and notice. On these findings of fact and conclusions of law and on the entire record, I issue the following recommended:[7]

ORDER

The Respondent, its officers, agents, successors, and assigns shall

1. Cease and desist from

(a) Failing and refusing to bargain collectively and in good faith with Local 863, International Brotherhood of Teamsters (the Union) as the exclusive collective-bargaining representative of the bargaining unit employees by making changes to

[7] If no exceptions are filed as provided in Sec. 102.46 of the Board's Rules and Regulations, the findings, conclusions, and recommended Order shall, as provided in Sec. 102.48 of the Board's Rules, be adopted by the Board and all objections to them shall be deemed waived for all purposes.

the employees' health care coverage, including the third-party administrator for its health care plan.

(b) Unilaterally changing the terms and conditions of employment of its unit employees.

(c) In any like or related manner interfering with, restraining, or coercing employees in the exercise of the rights guaranteed them by Section 7 of the Act.

2. Take the following affirmative action necessary to effectuate the policies of the Act.

(a) Upon the Union's request, rescind the modification to your terms and conditions of employment, in particular the modification of your health care plan that occurred on January 1, 2019, by restoring the terms and coverage provided under the Horizon Direct Access Plan until such time as we negotiate in good faith with the Union either to a new agreement or to impasse.

(b) Make whole bargaining unit employees for any losses they suffered or out-of-pocket expenses they incurred as a result of its unlawful conduct, in the manner set forth in *Ogle Protection Services*, 183 NLRB 662, 683 (1970), enfd. 444 F. 2d 502 (6th Cir. 1971), with interest as prescribed in *New Horizons*, 283 NLRB 1173 (1987), compounded daily as prescribed in *Kentucky River Medical Center*, 356 NLRB 6 (2010).

(c) Compensate affected employees for the adverse tax consequences, if any, of receiving lump-sum financial awards, and file with the Regional Director for Region 22, within 21 days of the date such awards are fixed, either by agreement or Board order, a report allocating the awarded amounts to the appropriate calendar year for each employee.

(d) Preserve and, within 14 days of a request, or such additional time as the Regional Director may allow for good cause shown, provide at a reasonable place designated by the Board or its agents, all payroll records, social security payment records, timecards, personnel records and reports, and all other records, including an electronic copy of such records if stored in electronic form, necessary to analyze the amount of monies due under the terms of this Order.

(e) Within 14 days after service by the Region, post at each of its Northern New Jersey facilities, copies of the attached notice marked "Appendix"[8] in both English and Spanish. Copies of the notice, on forms provided by the Regional Director for Region 22, after being signed by the Respondent's authorized representative, shall be posted by the Respondent and maintained for 60 consecutive days in conspicuous places, including all places where notices to employees are customarily posted. In addition to physical posting of paper notices, the notices shall be distributed electronically, such as by email, posting on an intranet or an internet site, and/or other electronic means, if the Respondent customarily communicates with its employees by such means. Reasonable steps shall be taken by the Respondent to ensure that the notices are not altered, defaced, or covered by any other material. If the Respondent has gone out of business or closed either of the facilities involved in these proceedings, the Respondent shall duplicate and mail, at its own expense,

[8] If this Order is enforced by a judgment of a United States court of appeals, the words in the notice reading "Posted by Order of the National Labor Relations Board" shall read "Posted Pursuant to a Judgment of the United States Court of Appeals Enforcing an Order of the National Labor Relations Board."

a copy of the notice to all current employees and former employees employed by the Respondent at any time since January 1, 2019.

(f) Within 21 days after service by the Region, file with the Regional Director for Region 22 a sworn certification of a responsible official on a form provided by the Region attesting to the steps that the Respondent has taken to comply.

Dated, Washington, D.C., September 17, 2021

Jeffrey Gardner
Administrative Law Judge

APPENDIX

NOTICE TO EMPLOYEES

Posted by Order of the
National Labor Relations Board
An Agency of the United States Government

The National Labor Relations Board has found that we violated Federal labor law and has ordered us to post and obey this notice.

FEDERAL LAW GIVES YOU THE RIGHT TO

Form, join, or assist a union
Choose representatives to bargain with us on your behalf
Act together with other employees for your benefit and protection
Choose not to engage in any of these protected activities.

WE WILL NOT do anything to prevent you from exercising these rights.

WE WILL NOT make unilateral changes to terms and conditions of employment without first bargaining with the Union, Local 863, International Brotherhood of Teamsters.

WE WILL NOT unilaterally alter the third-party administrator for the employees' health care plan without providing notice and an opportunity to bargain to the Union and without reaching agreement or overall good faith impasse in bargaining.

WE WILL NOT in any like or related manner fail and refuse bargain collectively and in good faith with the Union as the exclusive collective-bargaining representative of our employees in the unit or otherwise interfere with your rights under Section 7 of the Act.

WE WILL upon the Union's request, rescind the modification to your terms and conditions of employment, in particular the modification of your health care plan that occurred on January 1, 2019, by restoring the terms and coverage provided under the Horizon Direct Access Plan until such time as we negotiate in good faith with the Union either to a new agreement or to impasse.

WE WILL, make our unit employees whole for any loss suffered as a result of our unlawful conduct, including reimbursement of any increases in premiums, copays, coinsurance, and deductibles and for other out-of-pocket expenses, plus interest.

WE WILL before implementing any changes in wages, hours, or other terms and conditions of employment of unit employees, notify and, on request, bargain with the Union as the exclusive collective-bargaining representative of our bargaining unit employees.

COUNTY CONCRETE CORPORATION

(Employer)

Dated _____ By _____

(Representative) (Title)

The National Labor Relations Board is an independent Federal agency created in 1935 to enforce the National Labor Relations Act. It conducts secret-ballot elections to determine whether employees want union representation and it investigates and remedies unfair labor practices by employers and unions. To find out more about your rights under the Act and how to file a charge or election petition, you may speak confidentially to any agent with the Board's Regional Office set forth below:

20 Washington Place, 5th Floor, Newark, NJ 07102–3110
(973) 645–2100, Hours: 8:30 a.m. to 5 p.m.
You may also obtain information from the Board's website: www.nlrb.gov.

The Administrative Law Judge's decision can be found at www.nlrb.gov/case/22-CA-238625 or by using the QR code below. Alternatively, you can obtain a copy of the decision from the Executive Secretary, National Labor Relations Board, 1015 Half Street, S.E., Washington, D.C. 20570, or by calling (202) 273–1940.

THIS IS AN OFFICIAL NOTICE AND MUST NOT BE DEFACED BY ANYONE
THIS NOTICE MUST REMAIN POSTED FOR 60 CONSECUTIVE DAYS FROM THE DATE OF POSTING AND MUST NOT BE ALTERED, DEFACED, OR COVERED BY ANY OTHER MATERIAL. ANY QUESTIONS CONCERNING THIS NOTICE OR COMPLIANCE WITH ITS PROVISIONS MAY BE DIRECTED TO THE ABOVE REGIONAL OFFICE'S COMPLIANCE OFFICER, (862) 229–7055.